Manitoba

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Law Reform Commission

Commission de réforme du droit

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EXECUTIVE SUMMARY

DISCUSSION PAPER ON STERILIZATION OF MINORS AND MENTALLY INCOMPETENT ADULTS

The Manitoba Law Reform Commission's Discussion Paper on Sterilization of Minors and Mentally Incompetent Adults summarizes the law in the area, outlines the legal issues surrounding this topic, and poses various relevant questions on which respondents are requested to voice their opinions.

At this stage, the Commission neither advocates nor recommends any legislative proposal. The sole purpose of the Discussion Paper is to elicit the opinions, judgments and concerns of the public on this issue and on the possible options.

The following summarizes the contents of the Discussion Paper:

SCOPE OF DISCUSSION PAPER

The issues raised in the Discussion Paper affect a narrowly-defined section of our society: those who are legally incompetent to consent to medical treatment. Such legal incompetence stems from minority (being under 18 years of age) or from a certain level of mental disability in adults ("mental disability" includes mental retardation and mental illness). Not all mentally disabled people are thereby automatically incompetent to give consent.

Competent adults, whether mentally disabled or not, are not affected by these issues.

THE CURRENT LAW

No medical treatment or procedure can occur without the patient's consent. A doctor who proceeds without consent commits the tort of battery (unauthorized interference with a person's body) and can be sued. The doctor could also face a criminal charge of assault.

Valid consent cannot be given by a person who is legally incapable of giving consent. Most minors and some mentally disabled adults are, in law, mentally incompetent to give consent.

In this situation, the law permits certain substitute decision-makers to give consent on behalf of the minor or mentally incompetent person. The substitute decision-maker must make

the decision that is in the best interests of the person on whose behalf the decision-maker is giving consent.

The main authorized substitute decision-makers for minors are parents, legal guardians, or the courts (under their *parens patriae* jurisdiction). Parental and guardian authority to give substituted consent ends when the child attains the age of majority. The main authorized substitute decision-makers for mentally incompetent adults are the courts (under their *parens patriae* jurisdiction) or custodians or committees of the person under *The Mental Health Act*.

In Canada there is a significant limitation on the legal ability of an authorized substitute decision-maker to consent to medical treatment -- they cannot consent on behalf of a minor or mentally incompetent person to the performance of a non-therapeutic sterilization procedure. ("Sterilization" refers to any usually irreversible medical procedure that permanently terminates the ability to procreate). This law results from the 1986 decision of the Supreme Court of Canada in a case called *Re Eve*.

Authorized substitute decision-makers continue to be able to consent on behalf of an incompetent person where a therapeutic sterilization is involved. A "therapeutic sterilization", according to the Supreme Court, is a sterilization performed to protect a person's physical or mental health. By contrast, a "non-therapeutic sterilization" is one performed for social reasons, like contraception or hysterectomy for menstrual management.

The blanket prohibition against non-therapeutic sterilization created by the *Eve* case does prevent any possibility of a repetition of the past, shameful history of routine, mass involuntary sterilization of the mentally retarded. Yet the case has caused concern to some who say that this blanket prohibition can also unjustly prevent the performance of a non-therapeutic sterilization in those occasional cases where it would truly be in the individual best interests of the person concerned.

The law as it now exists due to the *Eve* case could be changed by provincial legislation. A statute could give a substitute decision-maker the authority to consent to a non-therapeutic sterilization on behalf of a person legally incompetent to consent personally.

ISSUES TO BE ADDRESSED

A. Is There a Need for a Legislative Response to the *Eve* Case?

This threshold and central question requires a resolution of individually valid but competing considerations, such as: the rights of the mentally incompetent to procreation, inviolability of the body, self-determination, positive self-image, and protection against potential abuse, versus inflexibility of the blanket prohibition, its legal foreclosure of consideration of individual circumstances, and its potential to jeopardize other legitimate values and needs of the mentally incompetent that maximize their potential for living a minimally supervised, relatively free life in the community.

Solely for the sake of discussion, the other issues to be addressed assume that a legislative response is appropriate.

B. What Should Legislation Provide?

The draft statute prepared by the Alberta Institute of Law Research and Reform is presented (in Appendix "A" of the Discussion Paper) for the purpose of providing a framework for discussion; it is the most recent, thoroughly-considered and comprehensive legislative model in Canada.

(a) Who Should be the Decision-Maker(s)?

(i) One decision-maker or two?

The two questions involved in decision-making about sterilizing a person incapable of consent are: (1) Is the person competent or incompetent to make the decision personally? If competent, the decision about sterilization is simply left up to the individual. (2) Should a sterilization be performed? There need not be the same decision-maker for each question.

(ii) Potential Decision-Makers

In whom should legislation vest the power to determine either or both of these questions? Possibilities include: doctors, parents/guardians/committees, a special tribunal, and the courts.

While there are important arguments for and against each one of these choices, a crucial factor is that any legislation in this area must comply with the *Charter of Rights and Freedoms*. Section 7 of the *Charter* protects the right to "security of the person" and says that no one can be deprived of it except "in accordance with the principles of fundamental justice". Such "due process" includes elements like the right to a full hearing, the right to counsel, and the right to know all the evidence.

Legislation which places an important non-therapeutic decision like this "in private hands" (for example, to be made privately between doctors and family or the like) would probably violate the *Charter*.

(b) The Need for Procedural Safeguards (Due Process)

Strong procedural safeguards are needed, not only to comply with section 7 of the *Charter*, but also to provide the best protection our legal system can against abuse of process or capricious decision-making.

The two main procedural guarantees that must be built into the system are: (1) independent legal representation for the minor or mentally incompetent person, and (2) the opportunity for a full hearing. Some specific features designed to promote a full hearing are presented for discussion, such as: mandatory expert evaluations of competence and risks relevant to a sterilization decision; empowering the decision-maker to make investigations and call witnesses on his or her own initiative; and providing for a discretionary meeting between the decision-maker and the minor or mentally incompetent person.

(c) Basis for Sterilization Decision -- "Substituted Judgment" or "Best Interests" Test?

Respondents are asked for their opinions about how best to judge whether sterilization is for the benefit of the person for whom it is sought: by using the "substituted judgment" test (where the decision-maker assesses all factors and tries to make the subjective decision the incompetent person would have personally made if not incompetent) or by using the "best interests" test (where the decision-maker assesses all subjective factors and tries to determine objectively what is in the best interests of the person)?

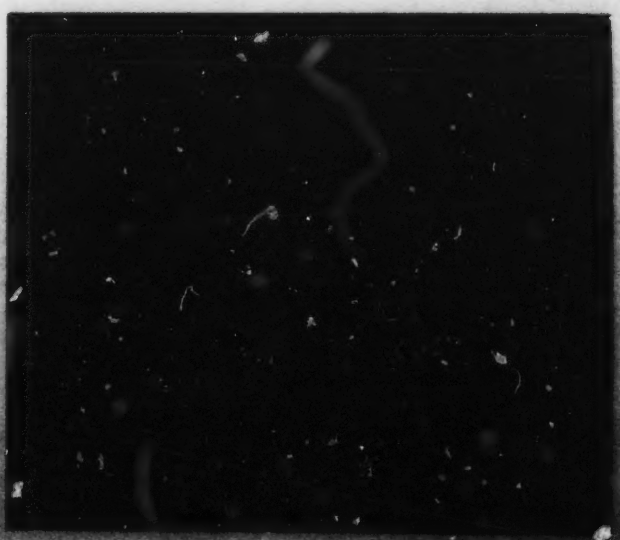
(d) What Factors Should the Decision-maker Consider Before Authorizing a Non-therapeutic Sterilization?

Any legislation in this area should list certain mandatory factors which the decision-maker must take into consideration in reaching a decision, so as to ensure the most safeguarded and

fullest possible hearing. Fifteen factors listed in the Alberta model statute are presented for respondents' comments. The factors include such considerations as age, likelihood of future competence, physical capacity and likely opportunity to reproduce, alternative birth control options, and the person's own expressed wishes and opinions.

CONCLUSION

The purpose of this Discussion Paper is to seek the opinions and ideas of the public. Persons wishing to respond to these issues are invited to submit their written comments to the Commission not later than May 31, 1991.



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DISCUSSION PAPER ON STERILIZATION OF MINORS AND MENTALLY INCOMPETENT ADULTS

November 1990

The Manitoba Law Reform Commission was established by *The Law Reform Commission Act* in 1970 and began functioning in 1971.

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We request that comments be submitted to the Commission not later than May 31, 1991.

TABLE OF CONTENTS

	PAGE #
CHAPTER 1 - INTRODUCTION	1
A. SCOPE OF DISCUSSION PAPER	2
B. VOICING YOUR OPINION	3
CHAPTER 2 - THE EXISTING LAW	4
A. NECESSITY FOR CONSENT TO MEDICAL PROCEDURES	4
B. WHO CAN BE SUBSTITUTE DECISION-MAKERS?	5
1. For Minors	5
(a) Parents	5
(b) Guardians	5
2. For Mentally Incompetent Adults	6
(a) Custodians	6
(b) Committees of the person	6
(c) Others	7
3. For Both Minors and Mentally Disabled Adults	8
(a) Persons having charge of another	8
(b) Courts (parens patriae)	8
C. CONSENT TO NON-THERAPEUTIC STERILIZATION	9
CHAPTER 3 - ISSUES TO BE ADDRESSED	11
A. ISSUE: IS THERE A NEED FOR A LEGISLATIVE RESPONSE TO THE EVE CASE?	11
1. There Is No Need for Legislation	12
2. There Is Need for Legislation	12
B. ISSUE: WHAT SHOULD LEGISLATION PROVIDE?	13
1. Who Should Be the Decision-Maker(s)?	14
(a) One decision-maker or two?	14

(b) Potential decision-makers 15
(i) Doctors 15
(ii) Parents/Guardians/Committees 16
(iii) Special tribunal 16
(iv) Court 17

2. The Need for Procedural Safeguards (Due Process) 19

(a) Independent legal representation 19
(b) Full hearing of the issues 19
(i) Mandatory expert evaluations 20
(ii) Judge has powers of commissioner 20
(iii) Discretionary meeting between judge and minor or mentally incompetent person 20

3. Basis for Sterilization Decision -- "Substituted Judgment" or "Best Interests" Test? 21

(a) The "substituted judgment" test 21
(b) The "best interests" test 22

4. What Factors Should the Decision-Maker Consider Before Authorizing a Non-therapeutic Sterilization? 23

(a) Likelihood of future competence 25
(b) Physical capacity to reproduce 25
(c) Factors raising risk of confusion with the interests of others 25

CHAPTER 4 - SUMMARY OF QUESTIONS 27

APPENDIX A - DRAFT ALBERTA STATUTE 29

CHAPTER 1

INTRODUCTION

Where a person, due to youth or mental disability, is legally incapable of consenting to a doctor's performance of a non-therapeutic sterilization procedure, who can lawfully consent on that person's behalf?

No one, said the Supreme Court of Canada in the 1986 case of *Re Eve*.[1] The Supreme Court unanimously decided that, in the absence of legislation, a court has no inherent jurisdiction to consent on behalf of such a person where the proposed sterilization is non-therapeutic in nature (i.e. performed for social reasons like contraception and not for the protection of the person's physical or mental health).

This decision leads to the same limitation on the authority of parents and guardians: "what the superior courts . . . [can] not do in the exercise of their broad discretionary protective jurisdiction, parents and guardians . . . [can] not do."[2]

Since no one can lawfully consent, a doctor who performs a non-therapeutic sterilization on a person incapable of consent could be sued for battery or charged with assault.

Parents, guardians and the court continue to be able to consent on behalf of an incompetent person where a therapeutic sterilization is involved. A "therapeutic sterilization", according to the Supreme Court, is a sterilization performed to protect a person's physical or mental health.[3]

The line between "therapeutic" and "non-therapeutic" is not absolutely clear, but the Supreme Court did make it clear that (except in rare and extraordinary circumstances where medically necessary to protect a person's physical or mental health) it considers sterilization for the purpose of contraception and hysterectomy for menstrual management to be "non-therapeutic".[4]

Most people are aware of the shameful and still recent history of routine, almost automatic, mass involuntary sterilization of mentally retarded people, many of whom were legally incapable of consent. For many decades, these people had little or no legal safeguards to protect them from abuse of this nature.

The *Eve* case effectively prevents this kind of situation from happening again by prohibiting, without exception, all non-therapeutic sterilizations performed on people who cannot

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[1]*Re Eve* (1986), 31 D.L.R. (4th) 1 (S.C.C.). Also reported as *E. (Mrs.)* v. *Eve*, [1986] 2 S.C.R. 388. All subsequent references are to the D.L.R. citation.

[2]Institute of Law Research and Reform, *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion #6, 1988) 12. The Institute of Law Research and Reform is now known as the Alberta Law Reform Institute.

[3]*Re Eve* (1986), 31 D.L.R. (4th) 1 at 28-29 (S.C.C.).

[4]*Re Eve* (1986), 31 D.L.R. (4th) 1 at 31-32 (S.C.C.).

legally consent personally. Yet the case has caused concern to some who say that the case's blanket prohibition can unjustly prevent the performance of a non-therapeutic sterilization in those occasional cases where it would truly be in the individual best interests of the person concerned.

According to this view, the *Eve* decision means that "[t]he message 'we will not risk letting you have babies' of the eugenic sterilization days has changed to the message 'we insist that you risk having babies' of the modern era."[5]

The law as it now exists due to the *Eve* case could be changed by provincial legislation. A statute could give a substitute decision-maker the authority to consent to a non-therapeutic sterilization on behalf of a person legally incompetent to consent personally.

The purpose of this Discussion Paper is to explore whether such a legislative response to the *Eve* case is needed and, if so, what form it should take and what legal protections and mechanisms would need to be put in place to protect against potential abuse.

This question is of undoubted practical importance to an appreciable, if indeterminate, number of Manitobans each year. The past incidence of non-therapeutic sterilizations performed on Manitobans legally incapable of consent is difficult to determine, because (as in other jurisdictions) there exists no readily accessible source of comprehensive or objective statistics. Of course, theoretically, no such non-therapeutic sterilizations have been performed since the *Eve* decision in late 1986.

At this stage, the Commission neither advocates nor recommends any legislative proposal. We are seeking only to describe the current state of the law, to outline possible options, and to elicit the opinions, judgments and concerns of the public on this issue and on the possible options. Only after receiving and considering the opinions and views of our respondents will the Commission decide whether to recommend law reform in this area.

In preparing this Discussion Paper, we make frequent reference to and use of the exhaustive analysis recently prepared in this area by the Alberta Institute of Law Research and Reform. The Institute's Discussion Paper[6] and Report[7] on this topic are recommended to readers who are interested in a more extensive discussion of these issues.

A. SCOPE OF DISCUSSION PAPER

It is important to appreciate that the issues raised in this Discussion Paper affect a narrowly-defined section of our society: those who are legally incompetent to consent to medical treatment. Such incompetence, in law, stems from minority (being under 18 years of age, regardless of the presence or absence of mental disability) or from a certain level of mental disability in adults.

"Mental disability" includes any mentally disabling condition, whether present since birth or resulting later from injury or disease. The general term "mental disability" would include, for example, mental retardation and mental illness.

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[5]Institute of Law Research and Reform, *Competence and Human Reproduction*, (Report #52, 1989) 37.

[6]Institute of Law Research and Reform, *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion #6, 1988).

[7]Institute of Law Research and Reform, *Competence and Human Reproduction*, (Report #52, 1989).

Not all mentally disabled people are thereby automatically incompetent to give consent. The issues raised in this Discussion Paper concern only those who are incompetent and do not affect competent adults whether mentally disabled or not.

Likewise, these issues concern no medical procedure other than sterilization, which for our purposes means any usually irreversible medical procedure that permanently terminates the ability to procreate. Common examples of sterilization procedures are tubal ligation, hysterectomy, and vasectomy.

B. VOICING YOUR OPINION

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We request that comments be submitted to the Commission not later than May 31, 1991.

CHAPTER 2

THE EXISTING LAW

A. NECESSITY FOR CONSENT TO MEDICAL PROCEDURES

Except in situations of medical emergency or where a statute provides otherwise,[1] a doctor must obtain a patient's consent before proceeding with medical treatment. A doctor who proceeds without such consent commits the tort of battery (unauthorized interference with a person's body) and can be sued. The doctor could also face a criminal charge of assault.[2]

Obtaining consent "is not a mere formality; it is an important individual right to have control over one's own body, even where medical treatment is involved. It is the patient, not the doctor, who decides whether surgery will be performed . . . ."[3]

Consent is valid if it meets all three of the following requirements:

(1) The patient must know what kind of medical treatment or surgery is proposed and what it may accomplish. A doctor cannot use consent to one procedure as authorization to perform a different or more extensive procedure. For example, consent to an operation on a toe does not authorize the performance of a spinal fusion,[4] nor does consent to the extraction of two teeth constitute consent to extraction of all the patient's teeth.[5] In both these cases, battery was committed.

Even if a patient is not informed by the doctor of all the attendant risks of the treatment, the patient's consent is still valid and the doctor will not commit battery by proceeding. But this same lack of "informed consent" means the doctor has breached the duty of disclosure owed to the patient; such a doctor could be sued for negligence.[6]

(2) The consent must be voluntary. The exercise of the patient's free will must be unclouded by coercion, deceit or fraudulent misrepresentation about the nature of the treatment.[7]

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[1]See, e.g. *The Public Health Act*, C.C.S.M. c. P210, ss. 19(1)(g) and 19(7)(g), where certain government officials or a justice can order a person with a communicable disease to "submit to or obtain medical treatment". This statute creates a special situation where a person's forced consent given under duress is nevertheless valid.

[2]*Criminal Code*, R.S.C. 1985, c. C-34, ss. 265-266.

[3]*Allan* v. *New Mount Sinai Hospital* (1980), 109 D.L.R. (3d) 634 at 642 (Ont. H.C.), rev'd on pleading issue (1981), 125 D.L.R. (3d) 276 (C.A.).

[4]*Schweitzer* v. *Central Hospital* (1974), 53 D.L.R. (3d) 494 (Ont. H.C.).

[5]*Parmley* v. *Parmley*, [1945] S.C.R. 635.

[6]*Reibl* v. *Hughes*, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1 (S.C.C.).

[7]*Re Dr. D.* (1970), 73 W.W.R. 627 (B.C.S.C.); *R.* v. *Maurantonio* (1967), 2 C.R.N.S. 375; leave to appeal to S.C.C. refused 2 C.R.N.S. 375n; *Bolduc* v. *R.*, [1967] S.C.R. 677.

(3) The patient must be competent to give consent. A person is legally competent to consent to medical treatment where the person fully understands and appreciates the nature and consequences of the particular treatment or operation, including the benefits and risks involved both in undergoing, and in failing to undergo, the procedure.

Two main groups of people are, generally speaking, unable to meet the above-noted test of competence and are therefore legally incompetent to give consent: minors (anyone under 18 years of age whether mentally disabled or not) and some mentally disabled adults.

Sometimes a minor close to the age of majority is sufficiently mentally mature to be considered legally competent to consent. In such cases, which are always judged on an individual basis, the "mature minor" exception operates and the minor's consent is valid.[8] However, the more serious the operation or treatment is (e.g. non-therapeutic sterilization), the more prudent it would be for a doctor to consider any minor to be incompetent to consent.

When a patient is incompetent to give personal consent, the doctor can seek and accept the necessary consent only from a legally authorized substitute decision-maker.

B. WHO CAN BE SUBSTITUTE DECISION-MAKERS?

1. For Minors

(a) Parents

Parental authority includes the legal power to consent to medical treatment on behalf of minor children in the parent's legal custody. The power to consent terminates when the child reaches the age of majority. This authority does not originate in statute law, but in the judge-made common law.

Parental consent to medical treatment must be exercised "in the best interests" of the child; it is the child's welfare that must be the primary consideration guiding the parent to consent or to refuse consent.

Parents have a positive legal duty to provide their children with the "necessaries of life", a concept which includes essential medical treatment and, therefore, the giving of their consent to it. The state and the courts will intervene to apprehend and protect a child whose parents fail to permit proper medical care necessary for the child's health or well-being.[9]

(b) Guardians

A guardian is a person who is not the child's parent and who is generally ordered by a court to be legal guardian of the child's person during the child's minority. Guardianship terminates when the child reaches the age of majority.

A guardian can either be an individual (where a private guardianship application has been made to court, for example, a grandparent who applies to be the grandchild's guardian)[10] or a

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[8] *J.S.C and C.H.C.* v. *Wren* (1986), 76 A.R. 115 at 117-118 (C.A.); *Johnston* v. *Wellesley Hospital* (1970), 17 D.L.R. (3d) 139 at 144-5 (Ont. H.C.).

[9] *The Child and Family Services Act*, C.C.S.M. c. C80, s. 17(2)(b)(iii).

[10] *The Child and Family Services Act*, C.C.S.M. c. C80, s. 77-81.

Child and Family Services agency (for example, where the court has ordered temporary or permanent guardianship because of child abuse).[11]

A parent can also voluntarily surrender guardianship of a child to a Child and Family Services agency for the purpose of putting the child up for adoption; this transfer of guardianship is the only kind that can be done by private agreement, without the need for a court order.[12]

Unless the court or a statute provides otherwise, a court-appointed guardian has the same authority and obligation as a parent to consent to medical treatment.

2. For Mentally Incompetent Adults

As noted above, legal guardianship and parental custody terminate when a child reaches adulthood at eighteen. This is so, whether or not the adult is or remains personally legally competent to assume the rights and powers once exercised on the child's behalf by the parent or guardian.

For adults who are legally incapable of consent (usually due to mental disability), the law specifies a limited number of legally authorized substitute decision-makers.

(a) Custodians

A custodian is a person in whose custody a mental retardate is placed by order of a provincial court judge.[13] Such a court order requires parental or guardian consent except in special circumstances.[14] A custodian has "such powers as would be exercisable by that person if the person were a parent of the mental retardate and the mental retardate were a child".[15]

(b) Committees of the person

A committee is a person to whom the custody of a mentally disordered person is committed under *The Mental Health Act*. The concept of "mentally disordered" includes, for this purpose, the condition of mental retardation.[16]

A "committee of the person" is authorized to make personal decisions for the committed person (like consent to medical treatment), but cannot handle the person's finances or business decisions unless also appointed as "committee of the estate".

The Court of Queen's Bench can appoint a committee of the person where it finds someone to be either "mentally disordered" within the meaning of *The Mental Health Act*[17] or

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[11] *The Child and Family Services Act*, C.C.S.M. c. C80, s. 38.

[12] *The Child and Family Services Act*, C.C.S.M. c. C80, s. 16.

[13] *The Mental Health Act*, C.C.S.M. c. M110, ss. 33-38.

[14] *The Mental Health Act*, C.C.S.M. c. M110, s. 34(4).

[15] *The Mental Health Act*, C.C.S.M. c. M110, s. 37(2).

[16] *The Mental Health Act*, C.C.S.M. c. M110, s. 1.

[17] *The Mental Health Act*, C.C.S.M. c. M110, ss. 56 and 80(1).

otherwise incapable of managing his or her own affairs due to "mental infirmity" (for example, through senility or habitual drunkenness).[18]

The Act itself automatically creates committeeship of the person in certain specified circumstances, without the need for a court order:

- where a doctor certifies that a patient admitted to a psychiatric facility is incapable of managing his or her own affairs;[19]
- where the provincial Director of Psychiatric Services makes an Order of Supervision concerning a mental retardate;[20]
- where the Director makes an Order of Supervision concerning a mentally disordered person who is not in a psychiatric facility or who is about to be released from one.[21]

In all cases, the Public Trustee of Manitoba will be the committee, where no other committee exists.[22] The Public Trustee is explicitly authorized to consent to any health care of the person[23] but is directed to consult with the person's family "where reasonably possible".[24]

(c) Others

On rare occasions, a substitute decision-maker can give consent even where none of the above legal mechanisms are in place.

Where a doctor determines that a patient admitted to a psychiatric facility is incompetent to consent, the Public Trustee can consent to "psychiatric or other medical treatment".[25]

Where an involuntarily-admitted patient in a psychiatric facility refuses treatment or where the patient's legally authorized substitute decision-maker refuses treatment on the patient's behalf, a doctor can apply to a government-appointed Review Board to obtain consent to "override" the refusal. The Review Board's power of consent is restricted to "specified psychiatric treatment and other related treatment"; it could not be sought for non-psychiatric medical treatment. An appeal of the Review Board's decision may be taken to the Court of Queen's Bench.[26]

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[18] *The Mental Health Act*, C.C.S.M. c. M110, ss. 76 and 80(1).

[19] *The Mental Health Act*, C.C.S.M. c. M110, ss. 26.11 and 80(1). A "psychiatric facility" does not include an institution for the mentally retarded.

[20] *The Mental Health Act*, C.C.S.M. c. M110, ss. 32 and 80(1). The Director can only make such an order when the parent or guardian of the mental retardate requests it. If the parent or guardian does not request it or oppose the idea, the Director would have to apply to court.

[21] *The Mental Health Act*, C.C.S.M. c. M110 ss. 26.12 and 80(1). Here, "mentally disordered" does not include mental retardation.

[22] *The Mental Health Act*, C.C.S.M. c. M110, s. 80(1).

[23] *The Mental Health Act*, C.C.S.M. c. M110, s. 80(1.1)(c).

[24] *The Mental Health Act*, C.C.S.M. c. M110, s. 80(1.2).

[25] *The Mental Health Act*, C.C.S.M. c. M110, ss. 24(3), (4), (5), (5.1), and (6).

[26] *The Mental Health Act*, C.C.S.M. c. M110, s. 25.

3. For Both Minors and Mentally Disabled Adults

(a) Persons having charge of another

The *Criminal Code*[27] imposes a legal duty on parents and legal guardians to provide "necessaries of life" to a child under the age of sixteen. "Necessaries of life" include medical aid or treatment needed to preserve life and health.[28] Breach of this duty is a criminal offence.

In addition, this duty is also imposed on children's caregivers who, without legal custody or guardianship, have a child under their care and control: foster parents, "factual" guardians, and the vague category of "head of a family".[29]

It is also imposed on those who have any person under their charge who is unable to provide personally for necessaries of life, and who is unable to withdraw from the charge of the caregiver by reason of "detention, age, illness, insanity or other cause".[30] This category of people to whom the duty is owed could include a mentally disabled adult living with parents, relatives, professional caregivers, or others whether or not an order of custodianship or committeeship is in existence.

It is arguable that a legal duty to provide medical treatment carries with it the authority to consent to that treatment on behalf of a patient who is incompetent to do so.[31] In life-threatening or very serious therapeutic situations, consent could possibly be given by these caregivers who otherwise have no general legal authority to consent.

Another situation where a caregiver without legal custody or guardianship can nevertheless legally consent to medical treatment on behalf of a child is where a Child and Family Services Agency has an allegedly abused child under apprehension but has not yet received court-ordered guardianship.[32]

(b) Courts (*parens patriae*)

Parens patriae jurisdiction originated "in the mists of antiquity"[33] as a power vested in the sovereign to protect from harm or exploitation those who are incapable of looking after themselves (basically, children and the mentally disabled). Eventually the exercise of this power became vested in the sovereign's courts; it continues to exist today in superior courts like the Queen's Bench of Manitoba.

This jurisdiction is broad, open-ended and therefore flexible to deal with new or previously uncontemplated situations. ". . . [T]he situations in which the courts can act where it is necessary to do so for the protection of mental incompetents and children have never been, and indeed cannot, be defined."[34]

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[27] *Criminal Code*, R.S.C. 1985, c. C-34, s. 215(1)(a).

[28] *R.* v. *Brooks* (1902), 5 C.C.C. 372 (B.C.S.C.); *R.* v. *Cyrenne, Cyrenne and Cramb* (1981), 62 C.C.C. (2d) 238 (Ont. Dist. Ct.).

[29] *Criminal Code*, R.S.C. 1985, c. C-34, s. 215(1)(a).

[30] *Criminal Code*, R.S.C. 1985, c. C-34, s. 215(1)(c).

[31] *Ritz* v. *Florida Patient's Compensation Fund* 436 So. 2d 987 (1983). *But see: Re Osinchuk* (1983), 45 A.R. 132 (Surr. Ct.).

[32] *The Child and Family Services Act*, C.C.S.M. c. C80, ss. 25(1)(b) and 25(2).

[33] *Re Eve* (1986), 31 D.L.R. (4th) 1 at 14 (S.C.C.), quoting H. Theobald, *The Law Relating to Lunacy* (1924).

[34] *Re Eve* (1986), 31 D.L.R. (4th) 1 at 17 (S.C.C.).

Parens patriae power must be used in the best interests, or for the benefit, of the person being protected.

Where common law or statute law is absent or inadequate to protect children or the mentally disabled, a court can intervene and use its *parens patriae* jurisdiction to order what is in the person's best interests, including the giving or refusing of consent to medical treatment.

C. CONSENT TO NON-THERAPEUTIC STERILIZATION

In Canada, however, there is a significant limitation on the legal ability of an authorized substitute decision-maker to consent to medical treatment. No authorized substitute decision-maker can consent on behalf of an incompetent minor or mentally incompetent person to the performance of a non-therapeutic sterilization procedure. This law results from the decision of the Supreme Court of Canada in a case called *Re Eve*.[35]

"Eve" was a 24-year-old woman, who was mildly to moderately retarded. She suffered from extreme expressive aphasia, so that she was unable to communicate perceived thoughts or concepts. At the school for retarded adults which Eve attended, she became close friends with a male student; however, the school authorities intervened to end the relationship.

Her mother, called "Mrs. E." by the courts, wanted Eve sterilized. Mrs. E. was concerned about the emotional effect on Eve if she were to experience pregnancy and childbirth, and felt that Eve could not cope with the duties of motherhood, so that the responsibility for raising the child would fall on Mrs. E. This would be difficult since Mrs. E. was widowed and nearly sixty. Evidence showed that Eve was incapable of effective alternate means of contraception.

Eve was incompetent to consent to medical treatment. Being an adult, she was no longer in her mother's legal custody. Therefore, Mrs. E. asked the court to make her the committee of Eve's person and to authorize her to consent on Eve's behalf to a tubal ligation for the purpose of contraception.

The Supreme Court stated that strong and unequivocal legislative language would be needed to give a committee the power to authorize a non-therapeutic sterilization. Legislative language that merely empowers a committee to consent to medical treatment is insufficient for that purpose.[36]

Since making Mrs. E. the committee of Eve would not therefore authorize the mother to give consent, the court went on to consider whether it could authorize the sterilization under its *parens patriae* power.

Parens patriae jurisdiction must only be exercised in the best interests of the person concerned. Mr. Justice La Forest, speaking for the unanimous Supreme Court, decided that:

> The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person. Accordingly, the procedure should never be authorized for non-therapeutic purposes under the *parens patriae* jurisdiction.[37]

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[35] *Re Eve* (1986), 31 D.L.R. (4th) 1 (S.C.C.); rev'g *Re Eve* (1981), 115 D.L.R. (3d) 282 (P.E.I. S.C., in banco); rev'g *sub nom Re E* (1979), 10 R.F.L. (2d) 317 (P.E.I. S.C.).

[36] *Re Eve* (1986), 31 D.L.R. (4th) 1 at 11 (S.C.C.).

[37] *Re Eve* (1986), 31 D.L.R. (4th) 1 at 32 (S.C.C.).

The Court said that the possibility of being wrong about whether a non-therapeutic sterilization is in a person's best interests makes the risk of authorizing the procedure too high; the sterilization cannot be reversed later if an error of judgment was originally made.[38]

If a court cannot lawfully consent to a non-therapeutic sterilization, it follows that neither can a parent or other substitute decision-maker. The practical result of the *Eve* decision is that no one can consent to a non-therapeutic sterilization on behalf of a person who is legally incapable, due to youth or mental disability, of consenting personally.

This decision does not affect the ability of courts, parents and other substitute decision-makers to consent to therapeutic procedures, including therapeutic sterilization (an obvious example of which is removal of the ovaries to cure ovarian cancer). The Supreme Court defined a "therapeutic" operation as one whose performance is necessary to the physical or mental health of a person.[39] This definition excludes any consideration of social purposes.

An operation performed for social purposes is non-therapeutic by the Supreme Court's definition. The court clearly considers sterilization for contraception and hysterectomy for menstrual management to be procedures performed for social reasons alone and therefore non-therapeutic.[40]

The Supreme Court did not discuss the specifics of where the line is to be drawn between therapeutic and non-therapeutic sterilization, but simply stated that "utmost caution must be exercised"[41] and that "[m]arginal justifications must be weighed against what is in every case a grave intrusion on the physical and mental integrity of the person."[42]

As an example, the Supreme Court referred to a case where the British Columbia Court of Appeal had ordered a hysterectomy for menstrual management for a seriously retarded, pre-menstrual girl who allegedly had a phobic aversion to blood.[43] The Court of Appeal had characterized the sterilization as therapeutic, but the Supreme Court considered this case to be "at best dangerously close to the limits of the permissible."[44]

If social purposes are to be given a role in these matters, said the Supreme Court, the appropriate body to make that decision is the Legislature. It has the power to enact, subject to compliance with the *Canadian Charter of Rights and Freedoms*, a statute that would give a substitute decision-maker the authority to consent to a non-therapeutic sterilization and that would specify the procedure which must be followed.[45]

The threshold question, therefore, about which this Discussion Paper seeks the views and opinions of our respondents, is whether such a legislative response to the *Eve* decision is necessary.

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[38]*Re Eve* (1986), 31 D.L.R. (4th) 1 at 32 (S.C.C.).

[39]*Re Eve* (1986), 31 D.L.R. (4th) 1 at 29 (S.C.C.).

[40]*Re Eve* (1986), 31 D.L.R. (4th) 1 at 31-32 (S.C.C.).

[41]*Re Eve* (1986), 31 D.L.R. (4th) 1 at 34 (S.C.C.).

[42]*Re Eve* (1986), 31 D.L.R. (4th) 1 at 34 (S.C.C.).

[43]*Re K and Public Trustee* (1985), 19 D.L.R. (4th) 255 (B.C.C.A.); leave to appeal denied [1985] 4 W.W.R. 757 (S.C.C.).

[44]*Re Eve* (1986), 31 D.L.R. (4th) 1 at 34 (S.C.C.).

[45]*Re Eve* (1986), 31 D.L.R. (4th) 1 at 32-33 (S.C.C.).

CHAPTER 3

ISSUES TO BE ADDRESSED

A. ISSUE: IS THERE A NEED FOR A LEGISLATIVE RESPONSE TO THE EVE CASE?

This issue, in addition to being the threshold question, is also the central question of this whole contentious area: should mentally incompetent people ever have access to or be subject to non-therapeutic sterilization when they do not have the legal capacity to choose this procedure personally by consenting?

The question is quite rightly contentious, given the shameful history of abuse of the mentally disabled by the once-common practice of wholesale involuntary sterilization.

Eugenics theory, prevalent from the late 19th century until the 1930's, stated that all manner of physical, mental and social problems (including criminal behaviour, prostitution, illegitimacy, venereal disease, and poverty) could be eradicated by the simple device of involuntary sterilization of people having such problems, so that "undesirable" characteristics would not be genetically transferred to offspring.[1]

Although now known to be manifestly unscientific, sometimes racist and always irrational, this "genetic" explanation of human behaviour was supported by many social theorists, reformers, doctors, psychologists and social workers.[2] It also received a considerable degree of judicial and legislative acceptance in both the United States[3] and Canada. British Columbia[4] and Alberta,[5] for example, had involuntary sterilization legislation, originally based on eugenic ideas and aimed primarily at mentally retarded people, in effect until the early 1970's.

Especially susceptible to abuse by involuntary sterilization were people perceived to be "mentally undesirable" by those having power over them. Even after the popularity of strict eugenics theory waned, the unexamined assumption remained that sterilization is always and unquestionably in the best interests of the mentally retarded. Only recently has this assumption begun to be challenged.

Such a history demands that caution and sensitivity be used when discussing the question of whether there is a need for a legislative response to *Eve*. However, it is also understood that

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[1]See, e.g., B.M. Dickens, "Eugenic Recognition in Canadian Law" (1975), 13 Os. Hall L.J. 547; R.J. Cynkar "*Buck v. Bell*: 'Felt Necessities' Versus Fundamental Values?" (1981), 81 Colum. L. Rev. 1418.

[2]B.M. Dickens, "Eugenic Recognition in Canadian Law" (1975), 13 Os. Hall L.J. 547; R.J. Cynkar "*Buck v. Bell*: 'Felt Necessities' Versus Fundamental Values?" (1981), 81 Colum. L. Rev. 1418.

[3]For example, the case of *Buck* v. *Bell*, 274 U.S. 100 (1927) where Justice Oliver Wendell Holmes of the United States Supreme Court, ordering the involuntary sterilization of an allegedly mentally handicapped woman, made the notorious eugenics-based statement that "[t]hree generations of imbeciles are enough."

[4]*Sexual Sterilization Act*, S.B.C. 1933, c. 59; *The Sexual Sterilization Repeal Act*, S.B.C. 1973, c. 79.

[5]*Sexual Sterilization Act*, S.A. 1928, c. 37; *The Sexual Sterilization Repeal Act*, S.A. 1972, c. 37.

raising the question does not amount to advocacy for a return to wholesale involuntary sterilization, a position which surely no one would (or should) support today.

1. There Is No Need for Legislation

Some arguments that support this position include:

1) Because social values, and therefore judgment, continue to be clouded by prejudice about the mentally disabled, their rights to procreation, inviolability of the body, and self-determination must always be given priority over concerns relating to childbirth and child rearing, unless those concerns have a medical foundation.

2) The greatest protection against potential abuse by involuntary sterilization is to leave the law as settled by the *Eve* case, so that absolutely no non-therapeutic sterilizations can lawfully occur. This is so whether the potential abuse consists of indiscriminate mass sterilization (as in the past) or of making an individual decision that in fact really serves the interests of society or third parties, not the interests of the person being sterilized.

3) It is wrong to say that the *Eve* case denies mentally incompetent people the same choice as mentally competent people have to contraception by sterilization. The mental incompetent's inability to personally choose non-therapeutic sterilization means that no "choice" exists to be made. It does not mean that a choice continues to exist, the exercise of which may be transferred to a third party.

4) Even where it might appear that non-therapeutic sterilization is in the best interests of the person, the consequences risked by being wrong are unacceptably high, given the irreversible nature of the procedure.

5) Any benefits of non-therapeutic sterilization are outweighed by evidence that involuntary sterilization has a significant negative psychological impact on the mentally retarded, who view it as a symbol of reduced or degraded human status.[6] At a time when "normalization" of lifestyle and "integration" into the larger community are becoming the major goals of our social response to the needs of the mentally disabled, the importance to the achievement of these goals of positive self-image among the mentally disabled cannot be over-emphasized.

2. There Is Need for Legislation

Some arguments that support this position include:

1) The Supreme Court is wrong to define "best interests" in such a restrictive way that preservation of reproductive capacity is always given priority over other values and needs that a mentally incompetent person might legitimately have, such as:

- the same ability as mentally competent people to avoid potential or apprehended adverse medical side effects of using birth control pills or other, more controversial hormonal suppressants like Depo-provera;

- continued ability to accomplish goals and receive satisfaction through participation in work, educational and social activities, where such participation is jeopardized by pregnancy and child care responsibilities;

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[6] *Re Eve* (1986), 31 D.L.R. (4th) 1 at 30 (S.C.C.).

- the ability to form relationships and experience sexuality without risking pregnancy or paternity, where alternative means of contraception are not viable;

- the ability to maximize their potential for living a minimally supervised, relatively free life in the community.

2) The proposition that "non-therapeutic sterilization can never under any circumstances" be in the best interests of a mentally incompetent person is just as extreme, inflexible and ultimately unjust as the proposition that "non-therapeutic sterilization is always" in their best interests.

The British House of Lords, while deciding a 1987 case with facts similar to *Eve*, severely criticized the Supreme Court of Canada's blanket, "no-exceptions-allowed" prohibition on non-therapeutic sterilization. The House of Lords found this blanket prohibition to be "totally unconvincing and in startling contradiction to the welfare principle which should be the first and paramount consideration"[7] in these cases. The Supreme Court's distinction between "therapeutic" and "non-therapeutic" situations was dismissed by the House of Lords as "totally meaningless, and, if meaningful, quite irrelevant to the correct application of the welfare principle".[8]

With the *Eve* decision, the Supreme Court has foreclosed all consideration of individual circumstances that might, in occasional cases, support a non-therapeutic sterilization as being in a person's best interests. "Yet do not such persons, who have so many special needs and challenges, deserve individualized attention on this intensely personal issue? The Supreme Court of Canada said no."[9]

3) The existence of legislation creating a consent mechanism does not mean that consent will thereby be frequently or easily obtained. By legislatively clarifying the vague distinction between "therapeutic" and "non-therapeutic" cases, a statute can also mandate court scrutiny (and therefore potential refusal of consent) for "borderline cases" which, in the absence of legislation, might have proceeded without hindrance, given a willing doctor.

In order to facilitate full discussion, the remainder of this Chapter proceeds on the premise that legislation is appropriate in this area, so that issues and questions concerning such potential legislation can be identified for purposes of seeking respondents' opinions.

B. ISSUE: WHAT SHOULD LEGISLATION PROVIDE?

Any legislation creating a mechanism for consent to non-therapeutic sterilization must:

- be explicit and unambiguous;

- maximize the potential for careful, individualized, well-informed and well-considered decisions; and

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[7] *Re B (a minor) (wardship: sterilisation)*, [1988] 1 A.C. 199 at 203 (H.L.). The House of Lords is the British equivalent to our Supreme Court. Its decisions have no legal effect in Canada, but are regarded as influential.

[8] *Re B (a minor) (wardship: sterilisation)*, [1988] 1 A.C. 199 at 204 (H.L.). The "welfare principle" is another name for the "best interests" test.

[9] Bolton, M. Anne, "Whatever Happened to Eve? A Comment" (1988), 17 M.L.J. 226.

- satisfy the depth of scrutiny to which the courts will subject the legislation under the *Charter*.

In meeting these criteria, the legislation must address several key issues. These issues, and the various positions available on each, will be individually canvassed in the following pages, in order to facilitate the gathering of respondents' opinions on the preferred resolution of each issue.

For the purpose of discussion only, we attach as Appendix A to our Discussion Paper a copy of the model legislation prepared in this area by Alberta's Institute of Law Research and Reform. This draft legislation was prepared by the Institute and recommended to its provincial government[10] following extensive consultation and opinion-gathering about a preceding discussion paper issued by the Institute.[11]

Please understand that we are not formally recommending the adoption of the Alberta model statute in our province. We merely present the Alberta model to provide a framework or focal point for discussion because it represents the most recent, thoroughly-considered and comprehensive legislative model in Canada. Its provisions will be summarized under each of the key issues that follow.

1. Who Should Be the Decision-Maker(s)?

(a) One decision-maker or two?

There are really two questions involved in decision-making about sterilizing a person incapable of consent.

The first question concerns the person's competence - is the person legally capable or incapable of consent? If capable, the decision about sterilization is that person's to make and no one else's.

The second question, which arises only if the person is legally incapable of consent, is whether the sterilization should be performed.

When constructing a legislative mechanism to provide consent, it is not strictly necessary that the decision-maker be the same for each question. The Law Reform Commission of Canada, in its 1979 Working Paper on sterilization,[12] and the government of Ontario, in a 1980 Bill introduced (but not passed) in its Legislature,[13] both proposed a system of two decision-makers; a court would decide the question of competence and a special tribunal would decide the question of whether to sterilize.

The Alberta model, by contrast, proposes a court as the single decision-maker for both questions.

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[10]Institute of Law Research and Reform, *Competence and Human Reproduction* (Report #52, 1989). To date, the Alberta government has taken no steps to implement the Institute's recommended legislation.

[11]Institute of Law Research and Reform, *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion #6, 1988).

[12]Law Reform Commission of Canada, *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons* (Working Paper #24, 1979).

[13]1980 Ontario Bill, "An Act respecting Consent to Health Care Services".

Which is better: one decision-maker or two? A single decision-maker model has the advantage of being procedurally simpler because both questions can be dealt with in a single hearing. On the other hand, different kinds of expertise may be needed for each question and a single decision-maker may not have both kinds of expertise in sufficient quantity.

(b) Potential decision-makers

(i) Doctors

Should legislation vest a doctor with the power to determine competence or to authorize involuntary sterilization?

Arguments that support this position could include:

1) Doctors are bound by their code of ethics to act only in the best interests of their patients.

2) Doctors would be especially careful in deciding the question of competence because being wrong would make them susceptible to a lawsuit for battery.

3) The legislation could provide an extra safeguard by requiring a second medical opinion in all cases.

Arguments that do not support this position could include:

1) Our society rarely gives doctors such power to make decisions for their patients, except in emergency situations.

2) A decision to sterilize for contraceptive purposes or to perform a hysterectomy for menstrual management is not a strictly medical decision. Such a decision is "largely cultural and psycho-social in orientation" and therefore "falls outside the usual realm of clinical judgment for the purpose of medical treatment".[14]

3) If legislation places an important non-therapeutic decision like this in private hands, without the incompetent person having the right to a full hearing, independent representation, rights of appeal and the like (i.e. what is sometimes called "due process"), the legislation would in all probability violate the *Charter*. Section 7 of the *Charter* provides that:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.[15]

"Security of the person" means the right to the legal and uninterrupted enjoyment of a person's life, limbs, body, health and reputation.[16] The "principles of fundamental justice" include, at a minimum, procedural fairness,[17] but are not limited solely to

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[14]Institute of Law Research and Reform, *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion #6, 1988) 96.

[15]*Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11.

[16]*Re Budge and Workers' Compensation Board* (1987), 42 D.L.R. (4th) 649 (Alta. Q.B.).

[17]*Singh* v. *Minister of Employment and Immigration* (1985), 17 D.L.R. (4th) 422 (S.C.C.).

procedural matters.[18] The concept of "procedural fairness" includes such elements as the right to a full hearing, the right to counsel and the right to know all the evidence.

(ii) Parents/Guardians/Committees

Should legislation vest the person's parents, legal guardian or committee with the power to determine competence or to authorize involuntary sterilization?

Arguments that support this position could include:

1) The family/caregiver of the minor or mentally incompetent person know that person's needs and circumstances better than any one else. Their love and concern for the person would make them more compassionate decision-makers.

2) Non-therapeutic sterilization is, for all people, a private issue and for that reason, is best dealt with by the family/caregiver rather than by an outside organization.

Arguments that do not support this position could include:

1) There can be real or potential conflicts of interest between what is in the best interests of the minor or mentally disabled person and what is in the best interests of the family member or caregiver making the decision. There is a risk of the latter being unconsciously (or even sometimes consciously) substituted for the former.

> Where the purpose of the proposed sterilization is contraception or menstrual management the subjectivity that comes from close personal involvement may operate to the detriment rather than benefit of the mentally incompetent person. For example, the decision maker may wish the operation to take place for his own or family convenience - to avoid being burdened by the care of a child born to the mentally incompetent person or to avoid having to cope with the problem of menstrual management. He may have a tendency to overprotect the mentally disabled person rather than to let her experiment with success and failure in relationships and the expression of sexuality. He may be moved by concern for the family name. He may be talked into consenting to satisfy an institutional policy demanding sterilization for placement of persons in the institution.[19]

In other words, while love and close personal relationships are wonderful things, they also introduce a degree of subjectivity that can cause the fairness of the decision-making process to be questionable.

2) The same concerns about section 7 of the *Charter*, discussed above in the context of doctors, apply equally here. Again, it is probable that legislation placing this decision in "private hands" would violate the *Charter*.

(iii) Special tribunal

Should legislation vest a special tribunal with the power to determine competence or to authorize involuntary sterilization?

By "special tribunal" we mean a small panel of people with appropriate expertise, who are not judges of a court or even necessarily lawyers, but who are given statutory authority to decide

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[18] *Reference re Section 94(2) of the Motor Vehicle Act* (1985), 24 D.L.R. (4th) 536 (S.C.C.).

[19] Institute of Law Research and Reform, *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion #6, 1988) 97.

issues. Common examples of "special tribunals" are the Labour Relations Board, the Public Utilities Board, and the Criminal Injuries Compensation Board.[20]

Arguments that support this position could include:

1) Like a court, a special tribunal can be an impartial, external decision-maker that provides a full hearing of an issue with all the safeguards of procedural fairness. Yet, unlike a court, its procedures can be more flexible - for example, it can be set up to operate on an "inquiry" model rather than on the "adversarial" model used in the court system, and it can hold its hearings in different or more informal locations like hospitals or institutions.

2) The types of specialists or professionals appointed to the special tribunal can be "tailored" to fit the kind of decision the panel is called upon to make. For example, if the panel is to decide the question of competence, its members could include psychiatrists and lawyers. If the panel is to decide the question of whether a sterilization is appropriate, its members could include doctors and social workers.

3) So long as the legislation provides for a hearing, legal representation of the minor or mentally incompetent person, and specifies a list of mandatory factors to be taken into consideration when making a decision to sterilize, a special tribunal model should not violate section 7 of the *Charter*.[21]

Arguments that do not support this position could include:

1) Special tribunals whose members sit from time to time "as needed" (as opposed to sitting full-time like judges) can be less able to convene hearings quickly, because of timetabling conflicts and difficulties of the specialists/professionals who are its members. This can result in delays and procedural problems.

2) Cost of these proceedings to the parties would probably not be significantly less than going to court, simply because lawyers would probably still be hired to present most cases. The issue of cost will be discussed more fully in the next section.

(iv) Court

Should legislation vest the courts with the power to determine competence or to authorize involuntary sterilization?

Arguments that support this position could include:

1) Using the court system has advantages such as:

   - independence of adjudication;
   - impartiality of adjudication;
   - established public credibility about courts' adjudication. Because of the past traumatic history of eugenic sterilization, it is crucial that decisions made

[20]Constitutionally, there is unlikely to be a problem in giving statutory jurisdiction over sterilization decisions to a provincially-appointed tribunal. The Supreme Court of Canada has established that provincially-appointed courts may be given jurisdiction over guardianship matters: *Reference re s. 6 of Family Relations Act, 1978; A.G. (Ont.)* v. *A.G. (Can.)*, [1982] 3 W.W.R. 1.

[21]Keyserlingk, Edward W., "The Eve Decision--A Common Law Perspective" (1987), 18 R.G.D. 657 at 674.

under any legislation in this area be as free as possible from any perception of self-interest or "hidden agendas". As stated by the English House of Lords, "if the question whether . . . [to sterilize] is left to be decided without the involvement of the court, there may be a greater risk of it being decided wrongly, or at least of it being *thought* to have been decided wrongly . . .";[22]

- published and accessible written reasons for courts' decisions;
- well-established appeal routes.

2) Judges are experienced in:

- adjudicating individual rights;
- determining competence for various purposes;
- hearing and assessing the evidence of witnesses, including that of expert witnesses;
- giving all parties an equal opportunity to be heard.

3) "Involvement of the court in the decision to operate, if that is the decision reached, should serve to protect the doctor or doctors who perform the operation, and any others who may be concerned in it, from subsequent adverse criticisms or claims."[23]

4) Given the delicate balancing of rights which must be performed in the decision whether to sterilize, and given the existing common law as stated in the *Eve* case, it is possible that legislators and the courts may both regard this issue to be too important to be left to any decision-maker other than a judge. It is for this reason that the Alberta model specifies the Court of Queen's Bench as the decision-maker for both questions to be addressed.[24]

Arguments that do not support this position could include:

1) The court system operates according to a cumbersome, formal and adversarial process which may discourage parents or caregivers from bringing a court application for non-therapeutic sterilization even where it might otherwise benefit the person involved. As one judge has stated:

> Even the most loving and caring parents would hesitate before becoming involved in major litigation. Firstly, most parents could not afford to become involved in such litigation. Secondly, apart from expense, the parents have to face the emotional hurdles confronting them in a case of this kind. The burden of going through ordinary litigation is a heavy one for the litigants. It is a doubly heavy burden in a case of this kind. Thirdly, there is a complete loss of privacy by both the parents and the child. The intimate details of their life are exposed to public scrutiny.[25]

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[22] *In re F. (Mental Patient: Sterilisation)*, [1989] 2 W.L.R. 1025 at 1068.

[23] *In re F. (Mental Patient: Sterilisation)*, [1989] 2 W.L.R. 1025 at 1068 (H.L.).

[24] Institute of Law Research and Reform, *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion #6, 1988) 102; Institute of Law Research and Reform, *Competence and Human Reproduction* (Report #52, 1989) 60.

[25] *Re K and Public Trustee* (1985), 19 D.L.R. (4th) 255 at 278 (B.C.C.A.) per Anderson J.A.

2) A major consideration is the cost of court proceedings. The Alberta model addresses this issue[26] by providing that the judge may order that the costs of the proceeding, reports or investigations be paid by the provincial government where the judge is satisfied that payment would be a hardship for the person making the application or for the person in respect of whom the application is made. In Manitoba, assistance could also be made available to poor families under the government's Legal Aid plan.

2. The Need for Procedural Safeguards (Due Process)

As previously discussed, section 7 of the *Charter* will require the presence of careful, procedural safeguards in any legislation which allows a substitute decision-maker to consent to a non-therapeutic sterilization on behalf of a minor or mentally incompetent person.

Building procedural safeguards into the process is wise not only for the purpose of complying with the *Charter*; procedural safeguards are, moreover, the strongest protection that our legal system can provide against abuse of process or capricious decision-making.

The two main procedural guarantees that must be built into the system are independent legal representation for the minor or mentally incompetent person, and the opportunity for a full hearing of the issues. We present the Alberta model for discussion in this area and request our respondents' opinions about its provisions, especially about the provisions specifically highlighted in the next few pages.

(a) Independent legal representation

In *Eve*, the Supreme Court of Canada stated that, where an application is brought to court to authorize a *therapeutic* sterilization (i.e., in those cases where the boundary between therapeutic and non-therapeutic is unclear), it is "essential that the mentally incompetent have independent representation."[27] It follows that it is equally essential in a clearly non-therapeutic situation.

The Alberta model creates a process whereby a judge must appoint a lawyer for the minor or mentally incompetent person as soon as the application is brought (see sections 11(1)(b), 15 and 16).

The lawyer's explicit duty is to provide "independent representation" (section 15). "Independent" means that the lawyer shall take instructions from and act in the interests of only one person - the minor or mentally incompetent person. The lawyer shall not take instructions from or act in the interests of anyone else, such as parents, guardians or institutional caregivers.

The lawyer's duty is to ensure that the procedural requirements of the legislation are met, present evidence and arguments on behalf of the minor or mentally incompetent person, and cross-examine on the evidence of others.

(b) Full hearing of the issues

The Alberta model has a range of procedural devices designed to promote the fullest possible hearing. For example, it explicitly directs the court to provide the opportunity to be

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[26]See section 21(1)(a)(iv) of Appendix A.

[27]*Re Eve* (1986), 31 D.L.R. (4th) 1 at 37 (S.C.C.).

heard (section 18(3)) and explicitly allows for cross-examination of experts who present reports to the court (section 19). In addition to provisions addressing standard procedural rights and matters like notice (section 12) and appeals (section 23), the Alberta model proposes three main procedural safeguards in this area:

(i) Mandatory expert evaluations

The person who initiates the application is obliged to file, right at the start of the application, reports from both a physician and a psychologist containing their expert opinions on the competence of the minor or mentally disabled person to make a decision about sterilization, and the risks to that person's physical or mental health that are relevant to a sterilization decision (see section 11(2)).

(ii) Judge has powers of commissioner

In an ordinary, adversarial court case, the judge cannot use his or her own initiative to call witnesses; the judge is to be passive and let the parties present their cases as they see fit. The Alberta model, however, explicitly authorizes the judge to make investigations and, for that purpose, vests the judge with "the powers of a commissioner" (section 18).

This means that, if the judge is dissatisfied with the evidence and witnesses called by the parties (because their evidence is insufficient, incomplete, contradictory or simply does not deal with issues the judge wants addressed), the judge can take the initiative and bring in other witnesses to give evidence.

This provision maximizes the availability of information to the court. Its presence also acknowledges that the "traditional adversarial model" of court proceedings is inappropriate where a delicate substitute decision is being made for someone unable to make the decision personally.

(iii) Discretionary meeting between judge and minor or mentally incompetent person

The person in respect of whom the application is brought will not necessarily be present in the courtroom for the hearing (although his or her lawyer will always be). The judge may nevertheless want to meet with the person in order to obtain a personal impression of the person's mental competence or of the likely effect of sterilization. Section 17 of the Alberta model allows a judge to have such a meeting at his or her discretion. Such meetings would likely be more informal in setting than the courtroom (for example, in the judge's chambers or perhaps in an institution or group home).

The Alberta model does not make such a meeting mandatory, because it was felt that in some cases the evidence would show that a meeting would be pointless, or would not add anything to a judge's understanding.[28]

One criticism of this provision is that errors of judgment originating in the judge's personal assessment of the person during this informal private meeting would be virtually impossible to rectify by way of an appeal to a higher court. The Alberta Institute of Law Research and Reform defends the provision by pointing out that judges often draw conclusions based on their personal

[28]Institute of Law Research and Reform, *Competence and Human Reproduction* (Report #52, 1989) 82.

observation of parties and witnesses in other court proceedings and that this is accepted judicial practice.[29]

3. Basis for Sterilization Decision: "Substituted Judgment" or "Best Interests" Test?

In authorizing a non-therapeutic sterilization, the decision-maker's sole consideration should be that the sterilization will be of benefit to the person involved. By what conceptual standard, however, should the question of benefit be judged? What kind of test best assesses the benefit?

Courts currently use one of two tests in this area: the "substituted judgment" test (which derives from American jurisprudence) or the "best interests" test (which is the traditional English and Canadian approach).

Since any legislation would have to indicate the basis or test upon which a sterilization decision must be based, the question becomes: which of these two tests is preferable?

(a) The "substituted judgment" test

This test, which has been formulated only within the past decade by some American case law,[30] basically says that the court should assess all relevant factors and make the decision that the mentally incompetent person would have personally made if that person were not mentally incompetent.[31] In other words, the court must pretend, in the most subjective manner possible, that it is the person involved.

It is important to understand that ". . . in utilizing the doctrine the Court does not decide what is necessarily the best decision but rather what decision would be made by the incompetent person if he or she were competent."[32] In theory, therefore, a court might order a result that is not in the person's best interests (according to the "best interests" test) but is the result that the court thinks the person would personally have chosen, if competent to do so.

Supporters of this test say that it best preserves the dignity and integrity of the incompetent person. It values that specific person's individuality by allowing the person, through the "substituted judgment" of the court, to have the same choice about procreation as a mentally competent person.

Detractors of this test have two main criticisms. First, it can be factually difficult, if not impossible, to find any evidence or even clues about what the mentally incompetent person might feel about the issue, especially where the person has been mentally disabled since birth.[33]

Secondly, this test has been criticized as conceptually flawed because "it is obviously fiction to suggest that a decision so made is that of the mental incompetent, however much the court may try to put itself in her place. What the incompetent would do if she or he could make

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[29]Institute of Law Research and Reform, *Competence and Human Reproduction* (Report #52, 1989) 83.

[30]See, e.g.: *In re Grady*, 426 A.2d 467 (1981 N.J. S.C.).

[31]E.S. Scott, "Sterilization of Mentally Retarded Persons: Reproductive Rights and Family Privacy", [1986] Duke L.J. 806 at 822-823.

[32]*In the matter of Mary Moe*, 432 N.E. 2d 712 (1982 Mass. S.J.C.) at 720.

[33]R.K. Sherlock and R.D. Sherlock, "Sterilizing the Retarded: Constitutional, Statutory and Policy Alternatives" (1982), 60 N.C.L. Rev. 943 at 963-965.

the choice is simply a matter of speculation."[34] An American court that rejected the use of this test stated that:

> The fault we find . . . [with the "substituted judgment" test] is . . . first concluding, correctly we believe, that the right to sterilization is a personal choice, but then equating a decision made by others with the choice of the person to be sterilized. It clearly is not a personal choice, and no amount of legal legerdemain can make it so.
>
> . . . .
>
> We conclude that the question is not choice because it is sophistry to refer to it as such, but rather the question is whether there is a method by which others, acting in behalf of the person's best interests and in the interests, such as they may be, of the state, can exercise the decision. Any governmentally sanctioned (or ordered) procedure to sterilize a person who is incapable of giving consent must be denominated for what it is, that is, the state's intrusion into the determination of whether or not a person who makes no choice shall be allowed to procreate.[35]

(b) The "best interests" test

This is the traditional test used by courts when making a decision on behalf of a person who cannot make the decision personally. For example, it is the test used when deciding questions of custody of children, visiting rights, or any question being dealt with under a court's *parens patriae* jurisdiction.

The test is used by assessing and weighing all the circumstances relevant to the question being decided and then determining the solution that the court perceives to be in the person's best interests. The test makes no pretence of producing the decision that the person would necessarily have made personally (if able), although the person's wishes and opinions are a factor in the court's consideration of all the circumstances.

The "best interests" test is not wholly objective, nor is it wholly subjective. "It combines the objectivity of a reasonable person with the subjectivity of the circumstances of the particular individual for whom the decision is being made."[36] Its vague definition leaves wide discretion in the hands of the decision-maker.

The "best interests" test has the advantage of being well-known by the judiciary, who are accustomed to using it. Its discretion and lack of rigid definition make it flexible enough to accommodate unusual or unique circumstances and evolving social attitudes.

Detractors of this test criticize it as being unacceptably vague and too dependent on discretion in a situation where the decision being made is irreversible.[37] One American court that voiced this criticism did, however, suggest a possible safeguard against the vagueness of wide discretion:

> No one who has dealt with this standard [the "best interests" test] has expressed complete satisfaction with it. It is not an objective test, and it is not intended to be. The substantial workability of the test rests upon the informed fact-finding and the wise exercise of discretion by trial courts engendered by long experience with the standard. Importantly, however, most determinations made in the best interests of a child or of an incompetent person are not irreversible;

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[34] *Re Eve* (1986), 31 D.L.R. (4th) 1 at 35 (S.C.C.).

[35] *Re Guardianship of Eberhardy* (1981), 307 N.W. 2d 881 at 893 (1981 Wisc. S.C.).

[36] Institute of Law Research and Reform, *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion #6, 1988) 113.

[37] *Re Eve* (1986), 31 D.L.R. (4th) 1 at 32 (S.C.C.).

> and although a wrong decision may be damaging indeed, there is an opportunity for a certain amount of empiricism in the correction of errors of discretion. . . . . Sterilization as it is now understood by medical science is, however, substantially irreversible. . . . Thus, . . . [t]he judicial process could afford no method for correcting an error in the exercise of this discretion. The vague, although frequently useful, "best interest" analysis appears to be inadequate *unless there is an authoritative declaration of public policy to guide the exercise of that irreversible discretionary act.*[38]

The Alberta model, which adopts the "best interests" test as its standard, seeks to remedy the vagueness of this test by providing "an authoritative declaration of public policy" in the form of a statutory list of factors which a court *must* consider in reaching a decision.

4. What Factors Should the Decision-Maker Consider Before Authorizing a Non-therapeutic Sterilization?

Regardless of which test is chosen as the basis for a sterilization decision, it is advisable to list in the legislation specific factors which the decision-maker is obliged to consider in reaching a decision. The purpose of such a list of mandatory factors is to protect the individual for whom sterilization is sought by:

- ensuring that the fullest information possible will be presented to the decision-maker;
- reflecting adequately the complex mix of physical, psychological and social factors that must be addressed; and
- screening out those cases where sterilization is excessive or really serves the purposes of others.

The Alberta model, in sections 5, 6, 7 and 8, lists a number of mandatory considerations which we ask our respondents to consider and comment upon. The list contained in the Alberta model was mainly compiled from Canadian and American case law and is really a distillation of what the judiciary has said is necessary to fully consider the question of best interests.[39]

The primary mandatory consideration is contained in section 5 of the Alberta model. It provides that the decision-maker must consider the steps taken to inform the mentally incompetent person of factors relevant to undergoing or not undergoing sterilization and to assist the person in participating in the decision. The decision-maker must then consider the wishes and concerns expressed by the person after having been so informed and assisted. The purpose of this provision is to ensure that the incompetent person is fully informed and involved in the decision-making process to the extent that this is possible.

In addition to this primary factor, the Alberta model lists, in section 6, another fifteen mandatory considerations, plus a final category of "any other matter that the judge considers relevant" to cover any special or extraordinary individual circumstances not covered in the other categories. The fifteen mandatory considerations listed in section 6(1) are:

(a) the age of the person,

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[38] *In the Matter of the Guardianship of Joan I. Eberhardy, Incompetent*, 307 N.W. 2d 881 at 894 (1981 Wisc. S.C.) (emphasis added).

[39] See, e.g.: *Re Eve* (1981), 115 D.L.R. (3d) 283 (P.E.I. S.C.), especially the judgment of McDonald, J.; *Re K. and Public Trustee* (1985), 19 D.L.R. (4th) 255 (B.C.C.A.), especially the judgment of Anderson, J., [1985] 3 W.W.R. 204 (B.C.S.C.), especially the judgment of Wood, J.; *In re Grady* 426 A. 2d 467 (1981 N.J.S.C.).

(b) the likelihood that the person will become competent to consent to the proposed sterilization,

(c) the physical capacity of the person to reproduce,

(d) the likelihood that the person will engage in sexual activity,

(e) the risks to the physical health of the person if the sterilization is or is not performed,

(f) the risks to the mental health of the person if the sterilization is or is not performed,

(g) the availability and medical advisability of alternative means of medical treatment or contraception,

(h) the previous experience, if any, of the person with alternative means of medical treatment or contraception,

(i) the likelihood that any child of the person would be born with a physical or mental disability and the likely effect of that disability on the ability of the person to cope,

(j) the ability of the person to care for a child at the time of the application and any likely changes in that ability,

(k) the likelihood that a child of the person could be cared for by some other person,

(l) the likely effect of foregoing the proposed sterilization on the ability of those who care for the person to provide required care,

(m) the likely effect of the proposed sterilization on the opportunities the person will have for satisfying human interaction,

(n) the religious beliefs, cultural and other values of the person, and

(o) the wishes, concerns, religious beliefs, cultural and other values of the family or other interested person providing personal care insofar as they affect the interests of the person.

Where the application concerns a hysterectomy for menstrual management, there are an additional two factors to be considered in section 7: the availability and medical advisability of alternative means of menstrual management, and the previous experience (if any) of the person with such alternative means. Their purpose is to ensure a full exploration of all less drastic options.

Note that in subsection 6(2) it says that a factor listed in sections 6 or 7 need not be considered if the judge concludes that evidence about it "cannot reasonably be obtained." This recognizes that, in some cases, evidence will not be available on absolutely all of the factors. However, it does require reasonable effort be made to obtain evidence before a judge can disregard a factor. Note also that this provision does *not* apply to exempt consideration of the primary factor in section 5.

It was the experience of the Alberta Institute of Law Research and Reform that some of the mandatory factors proved to be more controversial than others. It is worth bearing this controversy in mind when commenting on the various factors. The Institute's reasoning behind the inclusion of the more controversial factors is as follows.

(a) Likelihood of future competence

Because the proper focus of any legislative response in this area is on the presence or absence of legal incompetence to consent, rather than on the presence or absence of mental disability *per se*, the draft statute is necessarily framed to apply to non-mentally disabled minors as well as those who are mentally disabled. It is recognized that non-mentally disabled minors are not, in the ordinary course of things, likely to be subject to sterilization. Nor should they be. But it would be discrimination under the *Charter* to include in the legislation only those minors who are also mentally disabled.

Because all minors are covered by the legislation, the mandatory factors of age (section 6(1)(a)) and the likelihood of future competence to consent (section 6(1)(b)) are crucial. These factors will prevent sterilizations being ordered for minors who will develop normally and be competent at age 18; the proper decision in these cases (should any application ever be brought) would be to refuse the application because the minor can make the decision personally in a few years.

These same factors also work to protect those adults whose incompetence is transient, unlikely to last for the duration of the person's reproductive life, and in whom normal mental development is likely to recur in the future.

(b) Physical capacity to reproduce

Section 6(1)(c) requires the decision-maker to consider the physical capacity of the person to reproduce. Obviously, if the person is not fertile anyway, any form of sterilization is an excessive, unnecessary intrusion.

The problem that the Alberta Institute of Law Research and Reform encountered is that fertility is a difficult thing to prove. If the person who brings the application had to prove the fertility of the person in respect of whom the application is brought, this onus would "be virtually impossible to meet in cases where no prior offspring have been conceived."[40]

For that reason, the Alberta model contains a presumption in section 8 that, where medical evidence indicates normal development of sexual organs, the decision-maker shall presume that the person has the physical capacity to reproduce. This presumption could be rebutted by the incompetent person's lawyer with evidence of the person's infertility.

(c) Factors raising risk of confusion with the interests of others

The decision-maker is to order a sterilization only where it is in the person's best interests. Factors that make a sterilization in the best interests of others (family, caregivers, society, etc.) are not relevant and are not to be considered.

However, is there a danger that the factors listed in s. 6(1)(i), (j), (k), (l) and (o) could be used as a "back door" method of bringing in consideration of the interests of others? The Alberta

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[40]Institute of Law Research and Reform, *Competence and Human Reproduction* (Report #52, 1989) 72.

model attempts to minimize this possibility by emphasizing that these factors are to be considered *only insofar* as they relate to and impact on the best interests of the person for whom sterilization is sought. To the extent, however, that they do affect that person's best interests, says the Alberta Institute, they are relevant factors to be considered and weighed with all the others:

> . . . [W]e think it would be a mistake to pretend that persons who are not competent to make sterilization decisions live in a social vacuum when in fact they depend on a network of family, friends and others to assist them in living as normal a life as possible. As we see it, the nature and extent to which a person can count on others is relevant to the determination of her present and likely future circumstances and this, in turn, is relevant to the consideration of her best interests.
>
> Admittedly, the distinction between the interests of others insofar as they affect the interests of the person whose sterilization is sought and the interests of others in their own right carries with it the risk of misapplication. However, we think the risk is minimized, if not eliminated, by the choice of a superior court judge as decision maker and by the provision of a broad range of substantive and procedural safeguards for the judge to observe.[41]

[41]Institute of Law Research and Reform, *Competence and Human Reproduction* (Report #52, 1989) 68.

CHAPTER 4

SUMMARY OF QUESTIONS

As stated in the Introduction, the purpose of this Discussion Paper is to raise issues and to seek the opinions and input of respondents. The major questions raised in this Paper are summarized for your convenience as follows:

1. Is there a need for a legislative response to the *Eve* case - i.e., a statute with a mechanism to apply for substituted consent for the performance of a non-therapeutic sterilization on a minor or mentally incompetent person?

2. Should such a statute specify the same or different decision-makers for the separate questions of competence and whether to authorize a non-therapeutic sterilization?

3. Who should the decision-maker(s) be? Doctors; parent/guardian/committee; special tribunal; court?

4. What do you think of the procedural safeguards created by the Alberta model, especially:

   - independent legal representation?
   - mandatory expert evaluations?
   - giving the decision-maker the powers of a commissioner?
   - discretionary meeting between the decision-maker and the person for whom sterilization is sought?

5. In deciding whether to authorize a non-therapeutic sterilization, should the decision-maker use the "substituted judgment" test or the "best interests" test?

6. What do you think of the Alberta model's list of mandatory factors to be considered by the decision-maker?

Persons wishing to respond to the issues raised in this Discussion Paper are invited to write to the Commission at the following address:

Manitoba Law Reform Commission
12th Floor
405 Broadway Avenue
Winnipeg, Manitoba
R3C 3L6

Unless clearly marked to the contrary, the Commission will assume that comments received are not confidential and that commentators agree to the Commission quoting from or referring to their comments, in whole or in part, and to the comments being attributed

to them. However, requests for confidentiality or anonymity will be respected to the extent permitted by *The Freedom of Information Act.*

We request that comments be submitted to the Commission not later than May 31, 1991.

APPENDIX A

DRAFT ALBERTA STATUTE

Competence and Human Reproduction Act

[Interpretation]

1(1) In this Act,

(a) "facility" means any establishment or class of establishment designated as a facility in the regulations under this Act;

(b) "interested person" means an adult who, because of his or her relationship to the person in respect of whom an order is sought, is concerned for the welfare of the person;

(c) "guardian" means

(i) in the case of a minor,

A) a person who is or is appointed a guardian under Part 7 of the *Domestic Relations Act*, or

B) a person who is a guardian under an agreement or order made pursuant to the *Child Welfare Act*;

(ii) in the case of an adult, a person who is appointed a guardian under the *Dependent Adults Act*;

(d) "judge" means a judge of the Court of Queen's Bench;

(e) "sterilization" means a surgical operation or other medical procedure or treatment that will or is likely to render a person permanently incapable of natural insemination or of becoming pregnant.

(2) For the purposes of this Act,

(a) a "sterilization for necessary medical treatment" is a sterilization that is medically necessary for the protection of the physical health of the person to be sterilized;

(b) a "hysterectomy for menstrual management" is a sterilization that

(i) is undertaken for the sole or primary purpose of eliminating menses,

(ii) is performed by the removal of the uterus, and

(iii) is not a sterilization for necessary medical treatment;

(c) an "elective sterilization" is a sterilization that is neither a sterilization for necessary medical treatment nor a hysterectomy for menstrual management;

(d) an adult is competent to consent to an elective sterilization if he or she is able to understand and appreciate

(i) the nature and consequences of natural insemination, pregnancy and childrearing,

(ii) the nature and consequences of the proposed sterilization including that it will or is likely to render the person permanently incapable of natural insemination or of becoming pregnant, and

(iii) the consequences of giving or withholding consent, and

(e) a female adult is competent to consent to a hysterectomy for menstrual management if, in addition to the matters described in clauses (i), (ii) and (iii) of paragraphs (d), she is able to understand and appreciate

(i) the nature and consequences of menstruation, and

(ii) the nature and consequences of the proposed hysterectomy including that the loss of the uterus will render the person permanently incapable of becoming pregnant.

[Scope]

2(1) Nothing in this Act affects

(a) the law regarding the performance of

(i) a sterilization for necessary medical treatment, or

(ii) a sterilization of an adult who is competent to consent to sterilization; or

(b) the jurisdiction of a judge to grant an injunction enjoining the performance of a sterilization.

(2) No sterilization other than a sterilization for necessary medical treatment shall be performed on

(a) a minor, or

(b) an adult who is not competent to consent to the proposed sterilization

unless it is authorized by an order made under this Act.

Part 1 - Sterilization Order

[Sterilization Orders Judge May Make]

3(1) A judge may make an order authorizing the performance of

(a) an elective sterilization, or

(b) a hysterectomy for menstrual management

on a person who is

(c) a minor, or

(d) an adult who is not competent to consent to the proposed sterilization.

(2) The judge may make the order subject to any conditions or restrictions the judge considers necessary.

(3) No elective sterilization shall be performed by hysterectomy unless a judge, by order, expressly so authorizes.

[Judge Must be Satisfied]

4(1) A judge shall not make an order under subsection (1) of section 3 unless the judge

(a) has found that the person in respect of whom the application is brought is

(i) a minor, or

(ii) an adult who is not competent to consent to the proposed sterilization,

(b) is satisfied that

(i) the person has been informed of the factors affecting the decision, and

(ii) has been assisted, to the full extent that his or her intellectual capacity allows, to participate in making a decision,

(c) has received evidence as to the wishes of the person after he or she has received such assistance, and

(d) is satisfied that the proposed sterilization would be in the best interests of the person to be sterilized;

(2) A judge shall not refuse to make an order under subsection (1) of section 3 merely because the sterilization is not necessary for the protection of physical or mental health.

[Wishes of Person in Respect of Whom Order Authorizing Sterilization is Sought]

5. In determining whether an order authorizing the performance of a sterilization would be in the best interests of the person in respect of whom the order is sought, the judge shall consider

(a) the steps taken

(i) to inform the person of factors relevant to the decision to undergo or forego a sterilization, and

(ii) to assist the person, to the full extent that his or her intellectual capacity allows, to participate in making a decision, and

(b) the wishes and concerns expressed by the person after having been so informed and assisted.

[Decision to Make Order for Elective Sterilization]

6(1) In addition to the matters referred to in section 5, before determining whether an order authorizing the performance of an elective sterilization would be in the best interests of the person in respect of whom the order is sought, the judge shall consider

(a) the age of the person,

(b) the likelihood that the person will become competent to consent to the proposed sterilization,

(c) the physical capacity of the person to reproduce,

(d) the likelihood that the person will engage in sexual activity,

(e) the risks to the physical health of the person if the sterilization is or is not performed,

(f) the risks to the mental health of the person if the sterilization is or is not performed,

(g) the availability and medical advisability of alternative means of medical treatment or contraception,

(h) the previous experience, if any, of the person with alternative means of medical treatment or contraception,

(i) the likelihood that any child of the person would be born with a physical or mental disability and the likely effect of that disability on the ability of the person to cope,

(j) the ability of the person to care for a child at the time of the application and any likely changes in that ability,

(k) the likelihood that a child of the person could be cared for by some other person,

(l) the likely effect of foregoing the proposed sterilization on the ability of those who care for the person to provide required care,

(m) the likely effect of the proposed sterilization on the opportunities the person will have for satisfying human interaction,

(n) the religious beliefs, cultural and other values of the person,

(o) the wishes, concerns, religious beliefs, cultural and other values of the family or other interested person providing personal care insofar as they affect the interests of the person, and

(p) any other matter that the judge considers relevant.

(2) The judge may make an order without considering a matter named in subsection (1) of this section or subsection (1) of section 7 where the judge is satisfied that evidence in respect of it cannot reasonably be obtained.

[Decision to Make Order for Hysterectomy for Menstrual Management]

7(1) In addition to the matters referred to in sections 5 and 6, before determining whether an order authorizing the performance of a hysterectomy for menstrual management would be in the best interests of the person in respect of whom the order is sought, the judge shall consider

(a) the availability and medical advisability of alternative means of menstrual management, and

(b) the previous experience, if any, of the person with alternative means of menstrual management.

(2) A hysterectomy for menstrual management shall be ordered only where no less drastic alternative method of menstrual management is reasonably available.

[Presumption of Physical Capacity]

8. For the purposes of this Act, the physical capacity of the person to reproduce shall be presumed if the medical evidence indicates normal development of sexual organs and does not raise doubt to the contrary.

[Declaration of Competence to Make a Sterilization Decision]

9. Where a judge finds that an adult person is mentally competent to consent to a proposed sterilization the judge may, by order, so declare.

Part 2 - Application for Order

[Applicant]

10. An application for an order under this Act may be made at any time by

(a) the person in respect of whom the order is sought,

(b) a parent of the person in respect of whom the order is sought,

(c) a guardian of the person in respect of whom the order is sought, or

(d) any interested person other than a person named in paragraph (b) or (c).

[Commencement by Originating Notice]

11(1) The application shall

(a) be made by originating notice, and

(b) include a request for the direction of a judge with respect to the appointment of a lawyer under section 15.

(2) The applicant shall file in support of the application the reports of

(a) a physician, and

(b) a psychologist

with respect to

(c) the competence of the person in respect of whom the application is brought to make a sterilization decision, and

(d) the risks to the physical or mental health of the person, as the case may be, that are relevant to the sterilization decision.

[Service of Notice]

12(1) The applicant shall serve notice of the application, together with the reports filed under section 11(2), on

(a) the person in respect of whom the application is made,

(b) the parents of the person in respect of whom the application is made, if any,

(c) the guardians of the person in respect of whom the application is made, if any,

(d) the person in charge of the facility, if the person in respect of whom the application is made is a resident of a facility,

(e) the lawyer appointed under section 15, and

(f) any other interested person whom the judge may direct.

(2) No order for service *ex juris* is required for service under subsection (1), but service outside Alberta must be effected at least 30 days before the date set for the hearing of the application, unless otherwise ordered by a judge.

(3) A judge may dispense with service on any of the persons referred to in subsection (1) except

(a) the person in respect of whom the application is made, and

(b) the lawyer appointed under section 15,

provided the judge is satisfied that it is not contrary to the best interests of the person in respect of whom the application is made to do so.

[Interested Person]

13. A judge may make an order that a person is or is not an interested person for a purpose named in this Act.

[Persons Who May be Heard]

14. A person served or required to be served under subsection (1) of section 12 or any other person whom the judge permits may appear and be heard on an application under this Act.

[Representation]

15. Before an application is heard, a judge shall appoint a lawyer to provide independent representation

(a) on the instructions of the person in respect of whom the application is made to the extent that the person is competent to give instructions, and

(b) of the interests of the person in respect of whom the application is made to the extent that the person is not competent to give instructions.

[Motion for Directions]

16. The lawyer appointed under section 15 may at any time apply to a judge for directions with respect to any matter arising in the proceedings, including

(a) the engagement of experts to provide evidence, and

(b) the payment of costs incurred in representing the interests of the person in respect of whom the application is made.

[Meeting with Person in Respect of Whom Application Made]

17. Where for any purpose connected with the application the judge is of the opinion that he or she should meet personally with the person in respect of whom the application is made, the judge shall do so.

[Investigation by Judge]

18(1) The judge may make whatever investigation the judge considers necessary with respect to any matter relating to the application.

(2) For the purpose of making an investigation pursuant to this section, the judge has the powers of a commissioner under the *Public Inquiries Act*.

(3) The judge shall give the parties an opportunity to be heard with respect to the evidence produced and matters arising from an investigation.

[Expert Reports]

19. Any party may cross-examine the person making a report filed in a proceeding under this Act.

Part 3 - General

[Effective Date of Order]

20. Notwithstanding anything in the Rules of Court to the contrary, an order under this Act shall not take effect until

(a) the dismissal or discontinuance of the appeal, where an appeal has been filed, or

(b) the expiration of the time allowed for appeal, where no appeal has been filed,

and the order shall be so endorsed.

[Costs]

21(1) A judge may at any time after the commencement of an application under this Act make an order that the costs of any application made or report or investigation ordered

(a) be paid by any or all of

(i) the person making the application;

(ii) the person in respect of whom the application is made;

(iii) the estate of the person in respect of whom the application is made where a trustee of the estate has been appointed;

(iv) the Crown in right of Alberta, where the judge is satisfied that it would be a hardship for any or all of the parties named in clauses (i), (ii) or (iii) to do so;

or

(b) be paid by the person making the application or a person opposing the application, where the judge is satisfied that the application or the opposition to the application, as the case may be, is frivolous or vexatious.

(2) An order for costs shall not be made under subsection (1) unless such notice as the Court thinks appropriate in the circumstances has been given to the person or party against whom costs are claimed.

[Order to Vary or Set Aside]

22. Where a judge is satisfied that, since the making of an order under this Act,

(a) there has been a material change in the circumstances of the person in respect of whom the application was brought, or

(b) material evidence is available which was not previously before the court,

and

(c) no substantial wrong or miscarriage of justice would result from his doing so,

the judge may

(d) vary or set aside the order, and

(e) make an order in substitution for an order that has been set aside.

[Appeals]

23(1) Any party to or person heard on an application under this Act may appeal the order of a judge to the Court of Appeal of Alberta.

(2) The notice of appeal shall be served on

(a) the person in respect of whom the application is made,

(b) the lawyer appointed under section 15,

(c) any parent, guardian or other interested person who appeared and made representations on the application in the Court, and

(d) any other interested person whom a judge of the Court of Appeal of Alberta may direct.

[Regulation-Making Power]

24. The Lieutenant-Governor in Council may, for the purposes of this Act, make regulations designating any establishment or class of establishment as a facility.

B. Dependent Adults Amendment Act

We recommend that the enactment of the *Competence and Human Reproduction Act*, or legislation of similar import, should be accompanied by the following amendment to the definition of "health care" in the *Dependent Adults Act*.

Dependent Adults Amendment Act

1. This Act amends the Dependent Adults Act.

2. The definition of "health care" in paragraph (b) of section 1 is amended by adding, at the end of clause (ii), the words "to which the *Competence and Human Reproduction Act* does not apply".

NOTES RE USE OF ALBERTA MODEL IN JURISDICTION OF MANITOBA

The language of the Alberta draft statute is compatible for use in Manitoba (which is of course a different legal jurisdiction) with the following minor changes:

1) The definition of "guardian" in s. 1(1)(c) would have to be altered, since Manitoba does not have the same provincial statutes relating to this area as does Alberta. A Manitoba version of this definition could be as follows:

> (c) "guardian" means
>
> (i) in the case of a minor, a person who is a guardian under an agreement or order made pursuant to *The Child and Family Services Act*;
>
> (ii) in the case of an adult, a person who is or is appointed a custodian or a committee of the person under *The Mental Health Act*.

Since Manitoba has no equivalent statute to Alberta's *Dependent Adults Act*, the proposed consequential amendments to that Act contained in Part B of the Alberta model would be unnecessary in Manitoba.

2) The word "Manitoba" should be substituted throughout for the word "Alberta" [ss. 12(2), 21(1)(a)(iv), 23(1), and 23(2)(d)].

3) The reference to the *Public Inquiries Act* in s. 18(2) would be a reference to *The Manitoba Evidence Act* in this province.

4) The reference in s. 20 to "Rules of Court" would be replaced by a reference to the Manitoba equivalent, the *Queen's Bench Act* and *Rules*.